HOSPITAL-BASED

RURAL HEALTH CLINICS

DIVISION OF MEDICAL ASSISTANCE

MEDICAID SCHEDULES

2008

INSTRUCTIONS

North Carolina Department of Health and Human Services
Division of Medical Assistance
Audit Section
421 Fayetteville Street Mall, Raleigh, NC 27601
2501 Mail Service Center - Raleigh, N.C. 27699-2501
Tel: (919) 647-8060 Fax: (919) 715-4711

Michael F. Easley, Governor
Dempsey Benton, Secretary

William W. Lawrence, Jr., M.D., Acting Director
Jim Flowers, Chief Audit Section

February 13, 2008

Dear FQHC \ RHC Provider:

In accordance with the Medicaid Participation Agreement Paragraphs 6 and 7, FQHC\RHC providers are required to file an annual year ending cost report with the Division of Medical Assistance. Providers can access the cost reporting forms and instructions on-line at http://www.ncdhhs.gov/dma/icfmr/fqhccost.htm and select the appropriate cost report.

Your cost report is due by the end of the fifth month of the year ending service period. The following information **must** be submitted **along with your original Medicaid FQHC\RHC cost report**:

- A copy of your facility Medicare cost report.
- A copy of your facility "crosswalk" working trial balance to support Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicaid report.
- Defined chart of account.
- Log of bad debts, if applicable.
- Financial Statements, audited or unaudited, at time of submission.

Please submit the above-referenced cost report and information to:

US Mail

Audit Section
Attn: Ron Fulton
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699–2501

Express Mail/Shipping

Audit Section
Attn: Ron Fulton
Division of Medical Assistance
421 Fayetteville St. Mall
Raleigh, NC 27601

If a settlement is due the Medicaid program, make check payable to ***Division of Medical Assistance*** for the amount due and remit it under separate cover to:

DHHS Accounts Receivable
Division of Medical Assistance
325 N. Salisbury Street
2022 Mail Service Center
Raleigh, NC 27699–2022

If you have questions, please contact Ron Fulton at (919) 647-8064 or e-mail Ronald.Fulton@ncmail.net.

Sincerely,

Kathy Cardenas
Audit Manager

DMA HOSPITAL-BASED RHC MEDICAID SCHEDULES
INSTRUCTIONS

RECOMMENDED SEQUENCE FOR COMPLETING MEDICAID SCHEDULES

The Medicaid Schedules are to be completed after the Medicare Cost Reporting Worksheets are completed.

Step Number	**Schedule**	**Cost Report Page**	**Instructions**
1	Geninfo	1	Page 2. Complete **Sections 1 - 5**.
2	DMA - HB1	2	Pages 3. Complete Schedule.
3	DMA - HB2	3	Pages 4. Complete Schedule.
4	DMA - HB3	4	Page 5. Complete Schedule.
5	DMA - HB4	5	Pages 6 - 7. Complete Schedule.
6	DMA - HB5	6	Page 8. **Complete Lines 1 - 3**.
7	DMA - HB6	7	Pages 9. Complete Schedule.
8	DMA - HB7	8	Page 10. Complete Schedule.
9	DMA - HB8	9	Page 10. Complete Schedule.
10	DMA - HB5	6	Page 8. **Complete Lines 4 - 9**.
11	DMA – HB9	10	Page 11. Complete Schedule.
12	Geninfo	1	Page 2. Complete **Certification Statement**.

DMA HOSPITAL-BASED RHC MEDICAID SCHEDULES
INSTRUCTIONS

DMA-SCHEDULES

GENERAL INFORMATION AND CERTIFICATION - PAGE 1

Warning: If you downloaded the Excel spreadsheet and are keying data into a worksheet, please remember you need only key data into the lightly shaded cells. Each worksheet contains formulas that process data only from the shaded cells and will not work correctly if you make entries in unshaded fields. If you experience problems with using Excel, simply print a blank copy of each schedule and fill it out using a pen or typewriter.

Note: Please follow the recommended sequence for completing your cost report schedules to assure the data flows correctly for all schedules.

1. Enter name, address, county and telephone number.

2. Enter cost reporting period. This period must coincide with the Medicare Cost Report.

3. Enter all Medicaid provider numbers and NPI numbers assigned to facility. If additional space is needed, attach a separate sheet with the additional provider numbers and NPI numbers.

4. Check appropriate box identifying type of control.

5. Enter individual we should contact to answer questions about cost report schedules.

6. Enter address we should mail all Medicaid settlements if different from address of facility in Item 1.

Certification Statement

Enter the full name of the facility and reporting period covered by the report.

Statement must be signed by officer or administrator of the facility **after** all schedules have been completed. The statement filed **must** have an original signature.

DMA HOSPITAL-BASED RHC MEDICAID SCHEDULES
INSTRUCTIONS

ANALYSIS OF DIRECT CORE COSTS - PAGE 2 / DMA-HB1

The purpose of this schedule is to compute Medicaid Net Direct Core Cost based on the Medicare Cost Report and the provider's working trial balance.

Line 1
Enter Total Direct Cost from the Medicare Cost Report, Worksheet A, Column 7, Line(s) applicable to the Rural Health Clinic(s) at the hospital.

Lines 2a - 2i are for identification of Other Ambulatory Services (Direct Non-Core) Costs:

Line 2a
Identify total Pharmacy cost included in Line 1, as documented in provider's working trial balance.

Line 2b
Identify total Dental cost included in Line 1, as documented in provider's working trial balance.

Line 2c
Identify total EPSDT cost included in Line 1, as documented in provider's working trial balance.

Line 2d
Identify total Maternity Care Coordination cost included in Line 1, as documented in provider's working trial balance.

Line 2e
Identify total Child Services Coordination cost included in Line 1, as documented in provider's working trial balance.

Line 2f
Identify total Radiology Services cost included in Line 1, as documented in provider's working trial balance.

Line 2g
Identify total Norplant Services cost included in Line 1, as documented in provider's working trial balance.

Line 2h
Identify total Physician Hospital Services cost included in Line 1, as documented in provider's working trial balance.

Line 2i
Identify total Other (Miscellaneous Ambulatory) cost included in Line 1, as documented in provider's working trial balance.

Line 3
Sum Lines 2a - 2i

Line 4
Subtract Line 3 from Line 1.

DMA HOSPITAL-BASED RHC MEDICAID SCHEDULES
INSTRUCTIONS

ANALYSIS OF ALLOCATED CORE COSTS - PAGE 3 / DMA-HB2

The purpose of this schedule is to identify all General Service Costs applicable to the Rural Health Clinic(s) and to allocate these costs between Core and Non-Core Services based on the Medicare Cost report and the provider's records.

Column 1

Lines 1a - 1w.

Enter the total General Service Cost for each cost center from the Medicare Cost Report, Worksheet B, Part I, Columns 1 - 26, Line(s) applicable to the Rural Health Clinic(s) of the hospital.

Line 2

Sum Lines 1a - 1w.

Line 3

Enter total amount from Line 2 which is applicable only to Core costs (Column 3, Line 2 plus all Pharmacy costs on line 1p).

Line 4

Subtract Line 3 from Line 2. (Transfer this figure to Schedule DMA-HB4, Line 3.)

Line 5

Divide Schedule DMA-HB1 Line 4 by Schedule DMA-HB1 Line 1. Round this ratio to two decimal places (0.00). (Transfer this ratio to Column 2, Lines 1a - 1o and 1q - 1w.)

Column 2

Lines 1a - 1o and Lines 1q - 1w

Enter ratio calculated in Column 1, Line 5.

Column 3

Lines 1a - 1w

Multiply Column 1 times Column 2 for each cost center.

Lines 2

Sum Lines 1a - 1w. (Transfer this amount to DMA-HB3, Line 1b.)

COST OF MEDICAID CORE SERVICES - PAGE 4 / DMA-HB3

The purpose of this schedule is to calculate the total cost for Medicaid Core Services.

Line 1a
Enter Direct Core Services Cost from Schedule DMA-HB1, Line 4, Column 2.

Line 1b
Enter Allocated Core Services Costs from Schedule DMA-HB2, Line 2, Column 3.

Line 1c
Enter sum of Line 1a plus Line 1b.

Line 2
Enter total number of Rural Health Clinic(s) Core Service visits. (From provider's records)

Line 3
Divide Line 1c by Line 2.

Line 4
Enter Upper Payment Limit per visit for specific Cost Reporting year. Note: If the hospital has less than 50 beds, enter N/A on this line.

Line 5
Enter Lessor of Line 3 or Line 4.

Line 6
Enter total number of Medicaid Covered Core Visits for Core Services excluding Mental Health Service Visits. (From provider's records)

Line 7
Multiply Line 5 times Line 6.

Line 8
Enter total number of Medicaid Covered Visits for Mental Health Services. (From provider's records)

Line 9
Multiply Line 5 times Line 8.

Line 10
Sum Line 7 plus Line 9.

ALLOCATION OF OVERHEAD COST - PAGE 5 / DMA-HB4

The purpose of this schedule is to allocate overhead costs to each ambulatory cost center and compute the average cost per encounter or unit of service.

Column 2

Lines 1a - 1i

Transfer costs from Schedule DMA-HB1 / Page 2 to the corresponding cost center.

Line 2

Sum Lines 1a - 1i.

Line 3

Enter overhead cost from Schedule DMA-HB2 / Page 3, Line 4.

Line 4

Divide Line 3 by Line 2. Round this amount to the fifth decimal place (0.00000).

Column 3

Line 1a

Multiply Unit Cost Multiplier (Column 2, Line 4) times Pharmacy Cost (Column 2, Line 1a) and enter amount on Line 1a.

Line 1b

Multiply Unit Cost Multiplier (Column 2, Line 4) times Dental Cost (Column 2, Line 1b) and enter amount on Line 1b.

Line 1c

Multiply Unit Cost Multiplier (Column 2, Line 4) times EPSDT Cost (Column 2, Line 1c) and enter amount on Line 1c.

Line 1d

Multiply Unit Cost Multiplier (Column 2, Line 4) times Maternity Care Coordination Cost (Column 2, Line 1d) and enter amount on Line 1d.

Line 1e

Multiply Unit Cost Multiplier (Column 2, Line 4) times Child Services Coordination Cost (Column 2, Line 1e) and enter amount on Line 1e.

Line 1f

Multiply Unit Cost Multiplier (Column 2, Line 4) times Radiology Services Cost (Column 2, Line 1f) and enter amount on Line 1f.

Line 1g

Multiply Unit Cost Multiplier (Column 2, Line 4) times Norplant Services Cost (Column 2, Line 1g) and enter amount on Line 1g.

PAGE 5 / DMA-HB4 continued

Line 1h

Multiply Unit Cost Multiplier (Column 2, Line 4) times Physician Hospital Services Cost (Column 2, Line 1h) and enter amount on Line 1h.

Line 1i

Multiply Unit Cost Multiplier (Column 2, Line 4) times Other Specified Cost (Column 2, Line 1i) and enter amount on Line 1i.

Line 2

Sum Lines 1a - 1i. Amount **must** agree with Overhead Cost in Column 2, Line 3.

Column 4

Lines 1a - 1i

Sum Columns 2 and 3 for each Line.

Line 2

Sum Columns 2 and 3.

Column 5

Lines 1a - 1i

Total number of encounters / units of service for **all** recipients served by the provider. This would include Medicare, Medicaid, private, and insurance recipients.

Number of prescriptions must be used for Pharmacy and encounters / units of service for all other Ambulatory Services.

Column 6

Lines 1a - 1i

Compute the average cost for each Ambulatory Service. Divide Column 4 by Column 5. Transfer amounts to Schedule DMA-HB5 / Column 2, Lines 1a - 1i.

DETERMINATION OF MEDICAID REIMBURSEMENT - PAGE 6 / DMA-HB5

The purpose of this schedule is to compute the Medicaid cost of each Ambulatory Service based on the number of **Medicaid** encounters / units of service, Total Reimbursement Cost (Core and Ambulatory), and Amount Due Provider / Program.

Column 2

Lines 1a - 1i

Transfer costs from Schedule DMA-HB4 / Page 5 to the corresponding cost center.

Column 3

Lines 1a - 1i

Enter total number of **Medicaid** encounters / units of service furnished by the provider for each Ambulatory Service. This information is from the provider's records.

Column 4

Lines 1a - 1i

Multiply Cost per Encounter (Column 2) times Number of Medicaid Encounters (Column 3).

Line 2

Enter Subtotal of Lines 1a - 1i.

Line 3

Enter Total Medicaid Core Cost transferred from Schedule DMA-HB3 / Page 4, Line 10.

Line 4

Enter Total Medicaid Cost of Pneumococcal and Influenza Vaccine Injections transferred from Schedule DMA-HB8 / Page 9, Column 2, Line 4.

Line 5

Enter Total of Lines 2, 3, and 4.

Line 6

Enter Amount Received / Receivable from Medicaid based on Core and Ambulatory Services furnished to Medicaid Recipients. Amount transferred from Schedule DMA-HB6, Page 7, Column 2, Line 4.

Line 7

Subtract Line 6 from Line 5.

Line 8

Enter Amount of Bad Debts from Schedule DMA-HB7 / Page 8, Line 5.

Line 9

Compute Amount Due Provider (Program). Add Lines 7 and 8.

SUMMARY OF MEDICAID PAYMENTS - PAGE 7 / DMA-HB6

The purpose of this schedule is to identify Medicaid Received / Receivable amounts and provider numbers for which EDS rendered payments. These amounts are applicable to Core and Ambulatory Services furnished during the cost reporting period. **Do not include Co-payments billed/received for Core Services, Fees billed/received for Carolina Access, or Medicare Crossover Payments. Co-payments for Ambulatory Services are included**.

Column 2

Lines 1a - 1i

Enter Received / Receivable amount for each Ambulatory Service based on the facility's records.

Line 2

Enter Received / Receivable amount for Core Services based on the facility's records.

Line 3

Enter Received / Receivable Third Party Liability amount for Ambulatory and Core Services based on the facility's records.

Line 4

Compute Total Medicaid Payments. Add Lines 1a - 1i, 2, and 3. Transfer this amount to Schedule DMA-HB5 / Page 6, Column 4, Line 6 and DMA-HB9 / Page 10, Line 6.

Column 3

Lines 1a - 1i

Enter provider numbers used by EDS to make payments for each Ambulatory Service. Please note, if more space is needed, provider numbers may be listed in the comments section at the bottom of the page.

Line 2

Enter provider numbers used by EDS to make payments for Core Services.

Line 3

Enter provider numbers which Third Party Liablilty payments were made for Medicaid covered services.

Comments

Use this section as needed. For example, cost reports with multiple providers may list the provider numbers here if column 3, lines 1a-1i has insufficient space.

BAD DEBTS - PAGE 8 / DMA-HB7

The purpose of this schedule is to compute the amount of Net Bad Debts incurred by the facility.

Line 1
Enter the total co-payment amount billed to Medicaid patients from the facility's records.

Line 2
Enter the co-payment amounts received from Medicaid patients from the facility's records.

Line 3
Compute Medicaid Bad Debts. Subtract Line 2 from Line 1.

Line 4
Enter any recovery of previous Medicaid amounts written off as Bad Debts from the facility's records.

Line 5
Compute Net Bad Debts. Subtract Line 4 from Line 3. Transfer this amount to Schedule DMA-HB5 / Page 6, Column 4, Line 8.

COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES - PAGE 9 / DMA-HB8

The purpose of this schedule is to compute the Medicaid cost of Pneumococcal and Influenza Vaccine Injections based on the number of injections for Medicaid recipients.

Columns 2 and 3
Line 1
Enter cost of Pneumococcal and Influenza Vaccine Injections in the applicable column from the provider's records.

Line 2
Enter the number of Pneumococcal and Influenza Vaccine Injections administered to Medicaid recipients in the applicable column. This information is from the provider's records.

Line 3
Multiply Cost per Vaccine Injection (Line 1) times number of Medicaid Vaccine Injections (Line 2).

Line 4
Enter the Medicaid cost of Pneumococcal and Influenza Vaccine Injections. Sum of Columns 2 and 3, Line 3. Transfer this amount to Schedule DMA-HB5 / Page 6, Column 4, Line 4.

PPS RECONCILIATION SCHEDULE – PAGE 10 / DMA-HB9

The purpose of this schedule is to compute PPS payments based on the number of Medicaid Encounters and identify Gross Amount Due Provider or Program.

Lines a - e

Enter total number of **Medicaid** encounters furnished by the provider for each Ambulatory Service. This information is from the providers records.

Line 1

Compute Total Medicaid Encounters. Enter subtotal of lines a - e.

Line 2

Enter PPS rate from DMA Rate Setting.

Line 3

Compute Prospective Payments. Multiply Line 1 times Line 2.

Line 4

Enter Total Reimbursable Costs from DMA-HB5. Sum of Line 5 and Line 8.

Line 5

Enter Greater of Line 3 or Line 4.

Line 6

Enter Amount Received from Medicaid from DMA-HB6 Line 4.

Line 7

Subtract Line 6 from Line 5. If this is a negative amount (Due Program), the total amount due **must** be remitted under separate cover with check made payable to ***Division of Medical Assistance*** to the address below:

DHHS Accounts Receivable
Division of Medical Assistance
325 N. Salisbury Street
2022 Mail Service Center
Raleigh, NC 27699–2022

DMA HOSPITAL-BASED RHC MEDICAID SCHEDULES
INSTRUCTIONS

After completing all schedules, print and complete the Certification Form as instructed below:

CERTIFICATION STATEMENT

Enter the full name of the facility and reporting period covered by the report.

Ensure the Certification Statement is signed by an officer or administrator of the facility after all schedules have been completed. The Audit Section **must** have an original signature on the submitted form or the cost report will be considered incomplete.

QUESTIONS ABOUT COST REPORT PREPARATION:

If you have questions about the preparation of the cost reporting forms, please contact Ron Fulton at (919) 647-8064 or e-mail Ronald.Fulton@ncmail.net.

DMA HOSPITAL-BASED RHC MEDICAID SCHEDULES
INSTRUCTIONS

The following information **must** be submitted **along with your original Medicaid FQHC\RHC cost report**:

_____ A copy of your facility Medicare cost report.

_____ A copy of your facility "crosswalk" working trial balance to support Medicare report.

_____ Supporting documentation and working papers including calculation of costs for the Medicare cost report.

_____ Supporting documentation and working papers including calculation of costs for the Medicaid cost report.

_____ Defined chart of account.

_____ Log of bad debts, if applicable.

_____ Financial Statements, audited or unaudited, at time of submission.